



# Patient Information

Patient Primary Care Physician: \_\_\_\_\_

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Mid: \_\_\_\_\_

D.O.B.: \_\_\_/\_\_\_/\_\_\_ Sex:  Male  Female SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Siblings: \_\_\_\_\_

Address Line 1: \_\_\_\_\_ Primary phone:  Home  Cell

Address Line 2: \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mother/legal guardian Relation: \_\_\_\_\_

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Mid: \_\_\_\_\_

D.O.B.: \_\_\_/\_\_\_/\_\_\_ Sex:  Male  Female SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital status: \_\_\_\_\_

Address Line 1: \_\_\_\_\_ Primary phone:  Home  Cell

Address Line 2: \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Ok to leave message:  Y /  N

Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Father/legal guardian Relation: \_\_\_\_\_

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Mid: \_\_\_\_\_

D.O.B.: \_\_\_/\_\_\_/\_\_\_ Sex:  Male  Female SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital status: \_\_\_\_\_

Address Line 1: \_\_\_\_\_ Primary phone:  Home  Cell

Address Line 2: \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Ok to leave message:  Y /  N

Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency contact (other than parent or legal guardian) Relation: \_\_\_\_\_

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Mid: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient

Race:  American indian/Alaska native  Asian  Black or African american  Hispanic  White  Other

Ethnicity:  Non-hispanic  Hispanic/Latino  Refused to report

Preferred language for healthcare discussion:  English  Spanish  Other \_\_\_\_\_

**Insurance information (primary)**

Insured's last name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ D.O.B.: \_\_\_/\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_  
Insured address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Insurance name: \_\_\_\_\_ Effective date: \_\_\_/\_\_\_/\_\_\_\_  
Employer name: \_\_\_\_\_

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**Insurance information (secondary)**

Insured's last name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ D.O.B.: \_\_\_/\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_  
Insured address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance name: \_\_\_\_\_ Effective date: \_\_\_/\_\_\_/\_\_\_\_  
Employer name: \_\_\_\_\_

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**Pharmacy**

1) Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_  
2) Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_

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**Preferred communications**

Phone call: <input type="checkbox"/>	Type of reminders/Follow-up:
Text messaging: <input type="checkbox"/>	Select all <input type="checkbox"/>
Preferred phone: (____) _____ - _____	Appointments <input type="checkbox"/>
Preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish	Lab results <input type="checkbox"/>
Preferred time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	Health maintenance <input type="checkbox"/>
Send reminder/Follow-up letters: <input type="checkbox"/>	Rx confirmation <input type="checkbox"/>
Send reminder/Follow-up emails: <input type="checkbox"/>	General notification <input type="checkbox"/>

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\_\_\_\_\_  
Parent/legal guardian signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date